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## ORIGINAL COMMUNICATIONS.

### THE MIDWIFE.*

HER FUTURE IN THE UNITED STATES.

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YOUR Committee has asked of us to answer three questions:

*"Has the trained and supervised midwife made good?*
*"Shall midwives be licensed, and shall midwives be abolished?"*

We have endeavored to follow closely the Committee's wording and have divided our paper into three parts, each part answering one of these questions.

We hope to show you in the following pages that the midwife never has and never can make good until she becomes a practising physician, thoroughly trained; that midwives should not be licensed save in those States where they are so numerous that they cannot be abolished at once, and concluding with the third question, by showing a system whereby the mothers of the future shall receive in their hours of greatest need the attention of men and women thoroughly grounded in obstetrics.

*"Has the trained and supervised midwife made good?"* In England the midwife has always done the brunt of obstetrics, save in the families of wealth and education. We find that the midwife was licensed until about 1810. During the nineteenth

* Read in the Section on Midwifery of the American Association for the Study and Prevention of Infant Mortality, Chicago, November 16–18, 1911.

century she was, in the main, dirty and unscrupulous. Finally, such a condition was reached that popular sentiment demanded a change and the Midwife Bill was passed in 1902, in spite of medical opposition. This has given England a fairly well-trained cleanly midwife, in place of the dirty midwife and the careless practitioner, but it has not instituted a new system, and in the light of modern medicine, it is of questionable advantage to the community, for it provides a double system in obstetrics; the midwife but scantily trained, depending upon the physician who is not certain to respond to her call.

Let us see just what this means. Some 30,000 women have taken enough practice away from the physicians to obtain a livelihood. Unquestionably the field of the physician has been invaded and the community is the loser because this form of practitioner is a make-shift, admittedly incapable of coping with the abnormalities of pregnancy, labor and the puerperium.

The more midwives there are and the more successful they are, just so much the worse for the community at large which is thereby being supplied by second-class service. And this is more true in England than in America for the English system of medical education averages far higher than in the United States of America.

With such inadequate training and such meager provision made for the supervision of the midwife, working out of harmony with a growing proportion of the medical profession, we can feel assured that the midwife in England has not made good when viewed in the light of the greatest benefit to the community as a whole.

Let us now turn to the continent of Europe to see how the question can be answered.

In practically the whole of Europe obstetrics has always been conducted by midwives and the system of training and regulation is much the same in all these countries, certainly the differences between the midwife in Italy, France, Austria and Germany are very slight indeed. As we have had the opportunity to study thoroughly the question in Germany let us take up the situation there in detail, and see the exact position of the German midwife. We feel that a study of her position will show not only the breadth and thoroughness of her training before she is allowed to assume definite responsibility, but also the complicated and complete supervision regarded as essential according to German ideals. Such a study we feel will show us what preparations we

must be ready and able to make should we decide to adopt a system with the midwife as the solution of our present condition and also what results we may fairly expect to obtain from such a system.

In Germany practically all the normal obstetrics both in and out of the kliniks is conducted by midwives. To be sure, an increasing number of persons are by the process of education and cultivation appealing to the physician for at least his supervision at such a trying time. In Germany all classes are represented in the schools for midwives from the professor's daughter to the simplest peasant girl.

We must realize that Germany has been training midwives for generations, to understand her hold upon the general public. The trained midwife followed as naturally in the course of development as the trained physician, and we find with the knowledge of the necessity of clean obstetrics, stringent laws were passed for her education and regulation.

The German midwife of to-day is trained in the government kliniks by university professors who are salaried by the state, the same professors in the main as those who are responsible for the training of the medical students. In most cases the midwife course is six months, all of which time she lives in the hospital where she is trained. Her text-book is issued by the government and constantly revised so as to be up to date. This she must know almost by heart from cover to cover. This book treats of anatomy, including the entire skeleton: the nervous, alimentary, and circulatory systems as well as the genitourinary tract. There is also considerable physiology and bacteriology as well as normal and pathological obstetrics. Besides this there is a statement of her legal status. This book is supplemented by lectures and explained by recitations occupying in all about twelve hours a week throughout the course.

She also has thorough drill in the principles of the diagnosis by means of abdominal palpation, auscultation, pelvimetry and vaginal examination. She has almost daily drill in the "vaginal touch" by means of the manikin and the fetal cadaver.

She is taught the most essential tests for the examination of the urine. She is required to make vaginal examinations and to deliver a certain number of cases in the confinement wards under the direction of the resident physicians and graduate midwives. Here also she is taught—as far as is possible in the limited time of her instruction—the principles of aseptic technic.

At the conclusion of the course the midwife must pass a rigid examination both oral and written on the subjects she has pursued. Besides answering questions for some fifteen minutes, the candidate must demonstrate her knowledge by making a diagnosis of presentation and position in the mannikin, outlining her methods of procedure in the given case. As we were present at such an examination we can definitely state that it is a thorough and severe test of the candidate's knowledge of the subjects—it is one that the average graduate of an American medical school would have difficulty in passing with distinction.

Now let us turn to the midwife in practice and see what her position is. She is constantly under the supervision of a physician in the government service whose duties are in a measure the same as our medical examiner plus many of those of a Board of Health officer.

To this officer the midwife must report before she enters upon her practice in the given locality; he examines her credentials and establishes her in practice and so long as she remains in his jurisdiction her work is constantly subjected to his supervision. To him she must report immediately all still births and deaths, all cases of puerperal fever and ophthalmia neonatorum. Her home, her equipment, her clothing and her person must always be ready for his inspection. She may lose her right to practice if her house is dirty or if she is caring for an obstetrical case under her own roof. The contents of her bag and her case book are outlined by law. She is required to wear clean and washable gowns when in attendance on cases. Her hands must be clean and the skin and nails in good condition at all times. She must report to this officer any septic lesion or ulcer on any part of her body. Violations of these rules will lead to swift punishment—fine or imprisonment, or both.

The midwife must also report immediately to some local physician any symptoms suggesting eclampsia or miscarriage or any serious complication of pregnancy.

She must be equally prompt in reporting any case of antepartum hemorrhage, contracted pelvis, or abnormal presentation —and this includes a breech presentation. Should the second stage last more than two hours without progress; the pulse or temperature rise above the limit considered not abnormal in obstetrics; the fetal heart rise above 180 or fall below 110; the placenta remain in the uterus too long after delivery; the uterus fail to contract and continue to bleed; or the perineum rupture during

delivery, the midwife in each and every instance must notify a physician in writing of the exact condition or communicate with him personally over the telephone. And the physician must in such a case respond at once unless actually engaged on a case that requires his immediate attention when he must so communicate to the midwife or the messenger. Should the midwife or the physician fail to obey these laws they are held liable to punishment.

In case an emergency arises where time is of utmost importance and her powers are limited by law from doing what she knows to be necessary, after notifying the physician, or even before if the emergency demands, it shall be her duty to do whatever seems necessary for her to perform—save only version and instrumental obstetrics—but in each and every instance she must communicate as soon as possible with the medical examiner, telling him the exact circumstances and abiding by his decision as to whether or not her action was justified.

This gives a rough picture of the duties and responsibilities of the German midwife and the careful supervision exercised over her. Added to all this she must return every few years for re-examination after a few days' residence in the klinik so that she will keep up to date.

But let us see if the midwife in practice lives up to all this. In the first place, one observing the work of the midwife in the confinement ward is struck by her lack of what is known as the "aseptic conscience"; that is, the knowledge that one is or is not surgically clean. After faithfully scrubbing her hands for the alloted fifteen minutes, the midwife will unconsciously touch something outside of the sterile field and continue as if surgically clean. This the writers have often observed. Of course there are exceptional pupil midwives who do not fall into this error and these are usually the ones who have graduated as nurses before beginning the training in the midwife school.

But one cannot help feeling that if these breaks in aseptic technic are made in the hospital where the pupil is working under vigilant instructors how much more apt she will be to fall into unsurgical habits while working in a peasant's home. This carelessness is even more marked in the older midwives when they return for instruction.

Obstetricians in Germany are far from satisfied with the present system. They admit it is illogical but it is so firmly established it seems impossible to make a change. Peurperal

fever is much more prevalent than should be. Prof. Bumm so states in his "Text-book on Obstetrics," in one year out of 2,000,000 births 5,000 deaths from puerperal fever were reported and of course many more failed to be accurately reported.

A year or so ago a Berlin physician, prominent in gynecology, wrote to a committee of the American Medical Association asking for information in regard to the number of deaths from puerperal fever in this country, as he understood that we were without midwives. The answer was made that not only were we without vital statistics of any value, but that we were in many states overrun with midwives. The Department of Medical Economics of the *Jour. of the A. M. A.*, referring to this correspondence adds "Midwifery is not so well regulated in this country as in Europe, and yet the harm done is probably less since midwives are not so numerous."

We have in Germany a system of training and regulation of the midwife so complete as to be almost ideal, a system of seemingly perfect harmony between the midwife and physician. But let us look a little closer at this very point and we will see why the thoughtful German obstetrician is dissatisfied with the present scheme.

There are rules for harmony laid down in the statute book, but the midwife is not well paid and it is profitable for her to deliver the case if possible without calling in the physician so she is all too apt to let the case go as long as seems safe without her falling into the clutches of the law. Then too the physician when called to such a case is far from being as careful as if it had been his case from the beginning, for it is so easy to say that had he been called earlier all would have been well. The obstetrician cannot give his best care to a case under such circumstances. Then there is the other great defect in the system that unlike any other branch of medicine there are two standards of excellence offered to the public.

Thus we see instead of perfect harmony a waste of precious minutes because of greed and ignorance; divided responsibility because of the nature of the system and also because of jealousy; and two standards of skill where science and logic demand but one. And so even on the continent where ages have given the midwife an established position yet the leading obstetricians will tell you that the midwife has not made good.

It is almost absurd to ask the question: "Has the trained and supervised midwife made good in America?" We have never had

a system of training of midwives worthy of the name; neither have we had any successful method of regulation, with the single possible exception of New York City. The fact is, the midwife is not a native product of America. They have always been here, but only incidentally, and only because America has always been receiving generous importations of immigrants from the Continent of Europe. We have never adopted in any State a system of obstetrics with the midwife as the working unit. It has almost been a rule, that the more immigrants arriving in a locality, the more midwives will flourish there, but as soon as the immigrant is assimilated, and becomes part of our civilization, then the midwife is no longer a factor in his home.

"*Shall Midwives be Licensed?*"—We suggest the following as a brief and fair summary of the minimum training which may be ordinarily demanded to-day of those who are to assume the care of the expectant mother. Ability to make a diagnosis of pregnancy, and to determine whether the bony development of the mother, is normal enough to make labor a safe procedure; knowledge of how to examine the urine and to test the blood pressure of the pregnant woman, so as to receive the first warning of threatened eclampsia. Ability to conduct a normal case of labor, and this is first of all asepsis—not only the theory, but the trained instinct of surgical cleanliness, and how it can be maintained. Ability to make the internal examination. A knowledge of anesthetics, ability to properly care for the breasts, to supervise the nursing and proper hygiene of the infant. In the light of modern medicine, we know these are the simplest requirements and the right of every mother in civilized communities, but as we read through this list, how many teachers of obstetrics would care to undertake the training of the midwife, as we have seen her in the city slums? How many would care to feel the responsibility for her work in practice?

The story of medical education in this country is not the story of complete success. We have made ourselves the jest of scientists throughout the rest of the world, by our lack of a uniformly high standard. Until we have solved the problem of how *not* to produce incompetent physicians, let us not complicate the problem by attempting to properly train a new class of practitioners. The opportunities for clinical instruction in our large cities are all too few to properly train our nurses and our doctors. How can we, for an instant, consider the training of the midwife as well?

The midwife is called in question to-day not because of the popular demand for her services, but because investigation into disease and death, has revealed her working in her filthy surroundings, and has shocked the medical and lay public into action.

The midwife is willing to undertake maternity work that no well-trained obstetrical nurse would think of attempting because in the first place she is ignorant of the situation; she has the over-confidence of half-knowledge; she is usually unprincipled, and callous of the feelings and welfare of her patients, and anxious only for her fee. She looks upon her work as a legitimate form of livelihood, not as an ennobling profession.

But let us look at the picture from another standpoint; and consider that the midwife is licensed. The question of regulation is one that goes hand in hand with the licensing power. We can take it for granted that all will agree that the licensed midwife must be regulated. How is that to be done? The obvious answer is by legislation, but we know by experience that in America legislation without public sentiment behind the law is absolutely futile.

Let us suppose for the sake of argument that the impossible has been accomplished—that we have an aroused community and laws as stringent as those of Germany, for the regulation of the midwife. We must realize that it means in each community inspectors trained in medicine and paid by the Government to give their exclusive time to supervising the midwife, and not only that, but a medical profession forced by law to respond to the call of the midwife in trouble. Do you honestly think for one moment that we could accomplish this in America? But let us again grant all this as possible, and consider whether it would be worth while; by gradual steps we should have evolved a double system of obstetrics enforced by the law through well-trained medical officers and backed by popular sentiment. Would it be a success? We answer, "No!" It would be a double system—two standards of excellence which can never work together, and yet based on the assumption that they are interlocking parts of the same machine. Why should we adopt in obstetrics this double system? Certainly, there can be no more important branch of medicine than this, and yet with the possible exception of ophthalmology, we have no attempt in any field of medicine to adopt a double system of practitioners. Why should we not oppose the midwife on the same ground that we oppose the optometrist; both, because of their limited training, are incompetent

to bear the responsibilities they attempt to assume, and whereas the worst the optometrist is likely to do is to subject his victim to financial loss and injure his eyesight, the midwife can and has, by her ignorance alone, cost the community the loss of two lives, and has not only escaped any punishment, but has been rewarded by a fee for her activities. And when we picture the unnecessary and enduring sorrow her ignorance has caused, we should think well before we put such power in her hands.

"*Shall the Midwife be Abolished?*"—We feel that this question should be answered emphatically in the affirmative when and where it is possible. We feel that in this position we are but keeping step with progress in preventative medicine and following out the logical solution of what is best and safest. But we go further and feel certain that the untrained and unscrupulous physician should be put in the same class with the midwife and laid aside as soon as is possible by guarded legislation and education of the public conscience. We are not satisfied with generalities. We feel that sweeping condemnation is not enough to bring about a change of any value. Let us not fall into such an error but show definitely and in detail just exactly how these much-needed reforms can be made. If our remarks seem didactic in dealing with conditions outside of our own state among surroundings we know little of—pardon us, me mean no possible offense. We are dealing with a problem about which it is next to impossible to know the details and the facts except at first hand.

To begin with let us show you the condition in Massachusetts and what we feel to be of vital importance in our own State. By the medical practice law midwives are excluded from the practice of obstetrics. They have been found violating the law and in two or three instances have been caught and convicted and have paid fines for practising medicine without a license. In spite of this some hundred and fifty women are practising as midwives. They are for the most part poorly trained and incompetent women. Their stronghold is in the manufacturing cities of about 100,000 population largely composed of immigrants. There are a few midwives in Boston but their practice is small. We feel that in Massachusetts under such favorable circumstances that the State and local medical societies should see to it that the law plainly written on the statute books be enforced and at the same time by the extension of dispensary systems provide for the immigrant population.

In States where the midwife is practically unknown see that

the medical practice law excludes the possibility of midwives practising within the limits of the State.

In States where the midwives are active but not numerous or well organized, license and regulate those in practice; outline for them the minimum standard for their cases and enforce at least this by taking away the licenses of those who violate the law. Renew the licenses every year and issues no new ones. Then the midwives will gradually be excluded from practice by their own incompetency and by the lapse of time. At the same time earnest endeavors must be made to provide competent obstetric care for the impecunious.

In States now overrun with midwives the task is harder but we think neither discouraging nor impossible. Have a thorough system of examination given in German, French and Italian and enough midwives will be able to pass such an examination to care for those who will only be satisfied with the obstetrics of the midwife. Then by inspection keep these women up to the highest standard they are capable of pursuing. Only allow those to practice who can pass this examination and have the examination and the license to practice an annual affair. Then by gradually raising the standard and by providing dispensary care for all who will apply, the problem in a few years would simplify itself. Of course this is with the understanding that the schools for midwives which have been proven on inspection to be merely diploma mills be abolished and the midwives drawn to supply the demand from the graduates of the continental schools—institutions with which we can never hope to compete.

We wish to present to you in detail two successful systems for providing obstetrical care for the poor of our cities. We offer these two not as better than other institutions elsewhere in the country, but merely to present the working plan of a system that can be applied with modification to any surroundings.

We first wish to show you the working of the Boston Lying-In Hospital, which last year cared for the confinement of 829 women in its wards, and 2,007 women in their own homes.

The patients are supervised in a pregnancy clinic, from the date of application, as soon as the condition is diagnosed until they fall in labor. The pregnancy clinic established May, 1911, is supervised by a corps of obstetricians who are assisted by the house officers and nurses in carrying out the work. When the patient falls in labor, she is either delivered in the wards of the hospital, or in her own home, depending on the nature of her case,

her place of residence, her inclination, and to a lesser degree, her ability to pay. If she is confined at her home, she is attended by a student externe. These student externes are for the most part under-graduates of the Harvard Medical School or post-graduate students from other institutions. How successfully this has worked out can best be shown by the statement that during the past year these 2,007 cases were delivered with no maternal mortality. Another encouraging and very practical feature has been that these 2,007 patients voluntarily contributed to the support of the hospital the sum of $2,571, and the total expenses of the out-patient department were $1,763.18, leaving a net gain of $807.82.

We feel that some such scheme as this can be carried out in every medical center, where medical schools are near at hand. In the smaller cities, away from medical schools, the young doctor, the visiting nurse association, and a few beds in a hospital, give a very excellent substitute for this more elaborate system. Let us look at such an institution at work. The city of Manchester, New Hampshire, has 70,000 inhabitants, including a large foreign population. In a central location is the building of the City Mission. Application is made to this institution by those unable to employ physicians. The home is visited, the need determined, and the district nurse is called in. About 150 obstetric cases are cared for annually. These are attended during confinement by the young physicians of the city who are members of the local medical society, and have signified their desire to be on call for obstetrical cases among the poor for two months each year, thus the young practitioner gains experience, and may even acquire patients for his future practice. For those cases which preseut complications, which cannot be properly dealt with in the patient's own home, there are three beds in the local hospital at the disposal of the City Mission. This institution is supported by public subscription, including donations from the various mill owners and manufactures of the town, and the various women's clubs of the churches. Such a plan it will be seen includes the social worker, the district nurse and the physician. To this is added possible hospital care in critical cases.

This system is efficient, economical and has proven satisfactory by years of service. We see no reason why it cannot be applied with modification in the smaller cities.

## CONCLUSION.

The object of the meeting of this section of our National Society we believe to be to fully consider the facts presented concerning midwives in general and the midwife in America in particular. From this consideration we should eventually draw conclusions and lay out a policy national in scope. Were such a policy accepted by th several states, each separate community must consider local conditions, opportunities and resources and apply the principles of such a policy as far as is possible to meet these given conditions. We all should return to our separate homes determined to carry out the plan which will finally give our community the best system of obstetric care which is practicable under the circumstances.

So let us be far-sighted in our plans and produce a policy nation-wide in scope and yet plastic enough to be shaped to the needs of each and every community. And let it all tend toward that goal for which we must all sooner or later strive, a single standard of obstetrical excellence, at the disposal of all, rich and poor alike. A standard which only takes into consideration the best possible, immediate, attention for the welfare of "All women in the perils of childbirth."

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